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THE JOURNAL OF SCHOOL HEALTH

Devoted to the interests and advancement of school health service and instruction. Your participation by membership is solicited.

Vol. XXIV MARCH, 1954 No. 3

VD EDUCATION IN SCHOOLS

ELENA M. SLIEPCEVICH
Associate Professor of Health Education
Springfield College, Springfield, Massachusetts

If one must justify the inclusion of a specific disease or illness in a course of study he usually approaches his task by citing the incidences of that condition among a particular school or college age group. The statistics or graphic representations are usually impressive and the recipient of this information displays at least a temporary interest in what has been revealed to him.

Although we know the teen-age years are the healthiest years of life, we also know that there exist certain conditions which are prevalent in this age group. According to the Metropolitan Life Insurance Company[1] (based on statistics for 1950-1952) the major threat to teen-age life is accidents, and the leading cause of death from disease throughout the teen-age period is cancer. Diseases of the heart, tuberculosis, acute poliomyelitis, complications of pregnancy and childbirth — all of these appear as major causes of death in specific age groups among teen-agers. Added to these causes of mortality we find some health problems which demand attention—colds, dental caries, defective vision, problems of mental and emotional adjustment, acne and some faulty food habits.

There seems to be no question that these causes of mortality and morbidity warrant inclusion in the high school and college health courses.

The purpose of this presentation is to discuss some of the basic issues regarding venereal disease education in the schools. Does venereal disease constitute a problem among teen-agers and young adults? Should the schools provide VD education? If so where should it be taught in the school curriculum? By whom? What should be the approach to this type of education? Is there any evidence to prove the effectiveness of VD education? What moral and social problems are involved?

1. "Health of Teen-Agers," *Statistical Bulletin*, New York: Metropolitan Life Insurance Company, Volume 34, No. 8, August, 1953, pages 1-4.

Presented before the School Health Education Section of the American Public Health Association, November 9, 1953.

Venereal Disease Among Teen-Agers

The highest incidence of venereal disease is found in the early 20's — the age group immediately following the completion of the high school education. What significance does this statement have for educators?

According to 1952 statistics reported to the United States Public Health Service[2] the number of cases of gonorrhea and syphilis in a New England state was highest in the 20-24 year age group with the 25-29 age group second highest. In the reported cases of gonorrhea alone in this same state the females in the 15-19 age group ranked third highest among all age groups. It is significant to note that the incidence for syphilis shows a marked increase in the 15-19 age group, approximately 23 times greater than the 10-14 age group. A study in a mid-western state for the first six months of 1951 reveals similar data. In this same geographical area a study of early syphilis showed there were over 50 contacts from a 17-year-old girl in a five month period of 1953. These contacts ranged in age from 14-22 years, approximately one-third of which resulted in syphilis. In a far-western state for the year of 1951, the age distribution of gonorrhea was highest in the 20-24 year age group.

Noting this high incidence of venereal disease in the late teens and early adult years, is there not a need to take a second look at the place of venereal disease education in our school programs?

Why Education in Venereal Disease?

Unfortunately, education against venereal disease does not give the same insurance as vaccination against smallpox. It is generally recognized that the protective measures which one learns by observing certain hygienic principles or inoculating against some diseases should be a part of school health education. But the protective value of information about venereal disease is not quite so easy to apply. There are complex social and moral implications which must be taken into consideration.

"Vaccinate them against VD with Knowledge. The Take will depend on them. If they remember when they should, what they should, the vaccination will probably be successful."[3]

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2. United States Public Health Service, Venereal Disease Statistics Division, 1953.

3. Randall, Harriett B., M.D., "Sex Education in Tomorrow's Schools," *Journal of School Health*, March, 1948, Volume 18, No. 3, page 81.

Bigelow[4] has suggested four points in favor of teaching the important facts about venereal disease.

1. Scientific information concerning the causes and effects of syphilis and gonorrhea does prevent infection of some young persons who without such knowledge might become infected. (This statement can be supported by physicians who have testified to this effect.)

2. Scientific information as to the dangers of going without medical treatment, or of attempted self-treatment, does lead many persons to seek medical advice and treatment promptly, and especially to persist until treatment is adequate. (Public health authorities recognize this point.)

3. Positive information concerning social and public health relations of venereal diseases leads many citizens to support laws and education looking toward their control. (Health education of the public helps to strengthen our public health movements.)

4. Scientific teaching will tend to counteract some of the exaggeration which has appeared in the literature. (Exaggeration and misleading facts and figures can cause people to lose their faith and support in the program.)

Our philosophy of health education clearly points to the fact that knowledge of scientific information is only *one* aspect of our program. Development of wholesome and sound *attitudes* which guide the student in his pattern of *behavior* are essential if successful teaching is to result.

The Place of VD Education in the Curriculum

The examination of several popular high school health textbooks and some introductory college hygiene books revealed that the discussion of the venereal diseases, if included at all, was not consistently found under the same topics. Chapters on sex life, marriage and family relationships (1), or communicable diseases (2), or organization and functions (3) of health departments were the most common areas to which venereal disease education was related.

The AMA-NEA Joint Committee report states that "venereal disease should be taught in conjunction with units on other diseases."[5] Hoyman and Bibby have said "when the teacher is deal-

4. Bigelow, Maurice, "Why Youth Should Know the Important Facts About Venereal Diseases," *Journal of Social Hygiene*, Reprint, Volume 29, 1943.

5. Joint Committee of the American Medical Association and the National Education Association, Health Education, 1948, page 57.

ing with the causes and prevention of communicable diseases in general, there is no more reason to exclude diseases of the sex organs than those of the throat or other body parts . . . they (the pupils) should learn that gonorrhea and syphilis are also caused by living germs and can be prevented by avoiding sexual contact with an infected person."[6]

"The prevailing philosophy of the American Social Hygiene Association on the place of venereal disease education in the schools is that this information and education should be integrated with appropriate units or courses in health education, social studies, and biology and other sciences."[7] For example, facts concerncerning the venereal diseases would be included in units on communicable diseases. The mental health and emotional aspects of repeated contraction of venereal disease should be discussed. In social studies there would be opportunity to consider the phases dealing with public health programs, namely, casefinding, control measures, and cost to the community. Mention of venereal diseases in other times and other countries might be brought into units of history. Problems affecting family stability, and our men and women in the armed forces, could be treated in other appropriate units.

Biester, Griffiths, and Pearce[8] have developed a sample unit showing how a study of the venereal diseases can become one aspect of a complete unit on communicable diseases. They state for their objectives:

The educated person

1. Knows the nature and prevalence of the serious communicable diseases.
2. Understands how communicable diseases are spread from one person to another.
3. Knows what science has discovered about the prevention and treatment of the serious communicable diseases.
4. Avoids exposure to communicable diseases.
5. Supports and participates in community efforts to control communicable diseases.

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6. Bibby, Cyril and Howarl S. Hoyman, "Sex Education for What?" *Look*, February 27, 1951.

7. Personal Correspondence from Division of Education, American Social Hygiene Association, October 27, 1953.

8. Biester, Lillian L., William Griffiths, and N. O. Pearce, M.D., *Units in Personal and Human Relations*, Minneapolis: University of Minnesota, 1947, page 236.

General questions relating to causes, symptoms, effects, and treatments are included for each of the diseases. There are opportunities for student projects and suggested films. In the specific discussion of the venereal diseases the social implications of this health problem are not ignored.

Kirkendall[9] in describing a plan for a high-school program of personal and social guidance indicates that the topic of venereal diseases should be included in a unit on communicable diseases.

If sex education is to be taught in a positive manner with emphasis on the development of wholesome attitudes and a sound sense of values, it is not likely that a discussion of morbid examples of the effects of sexual promiscuity, or congenital syphilis, will contribute to the achievement of these objectives. The writer recalls a filmstrip, "The Story of Growing Up" which was used in conjunction with a discussion on boy-girl relationships before a young people's group. Parents had been invited to attend the session and to help answer questions which arose. Included in what might have been an excellent filmstrip was a frame which showed two big red letters, "VD" with two caricatured germs. The script read: "Boys and girls who have not learned to be grown up and control themselves, and who have sex relationships outside of marriage, expose themselves to venereal diseases. Two of these, syphilis and gonorrhea, are two of our worst diseases." In reply to a question of clarification on this information a mother volunteered to tell the group that they need not be concerned with these diseases after they are married, but stated that they were a kind of "punishment" for promiscuous conduct before marriage. Was it any wonder that the informal discussions after the meeting were centered on these diseases rather than on normal relationships? These young people found it difficult to accept a statement which implied that a mysterious marriage ceremony of some minutes provided immunization forever!

Planning Course Content

Those who assume the responsibility for venereal disease education in the school program should utilize the many phases of this topic in planning course content. There must be constant awareness of new developments and trends so that instruction will be based on current findings and approaches that are being used in attacking the problem.

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9. Kirkendall, Lester A., Sex Education as Human Relations, New York: Inor Publishing Company, Inc., 1950, page 189.

The prevalence of the diseases in the total population is an indication that a program of continuing education is necessary. It is difficult to estimate the number of cases because it is obvious that all cases are not reported. According to the United States Public Health Service, Venereal Disease Division, there were a total of 475,088 new cases of VD reported in 1951. In 2 million selectees examined for military service among the white males 1.74% were found to be syphilitic and 25.2% of non-whites were infected![10]

We must recognize that although venereal disease may affect any person, there are certain groups and areas in our population which have a higher rate in incidence.

A study in Georgia[11] showed that low-socio-economic conditions have a direct relationship to a high prevalence rate of syphilis. A low level of educational attainment and mental ability appeared as a common characteristic among 500 venereally diseased women at a mid-western Medical Center.[12] The number of infectious cases in the population, sexual promiscuity, the high rate of communicability and the mobile nature of our population all contribute towards its increase.

High school students will find it of interest to learn about pre-marital blood tests and blood tests for expectant mothers. To know that laws requiring drops of silver nitrate in the new-born babies' eyes are to prevent gonorrhea infection will make this information meaningful to them. The importance which the World Health Organization has attached to the control of venereal disease can be pointed out to them by its rank as one of the three diseases to receive priority attention. They may want to discuss the international aspects of this problem and the necessity for cooperation by all countries in its control.

New Trends in Venereal Disease Programs

Although emphasis is on treatment, case-finding, including contact investigation, is the backbone of the control program. "You can't control VD if you don't find the cases." With the newer and more rapid methods of treatment through the use of the anti-

10. United States Public Health Service, *Venereal Disease Information*, October, 1945.

11. Bowdoin, C. C., et. al., "Socio-Economic Factors in Syphilis Prevalence. *Journal of Venereal Diseases Information*, Volume 30, No. 5, May, 1949, pages 131-139.

12. Wertz and Rachlen, "Mental Ability and Educational Allotment of 500 Venereally Infected Females, *Journal of Social Hygiene*, Volume 31, No. 5, May, 1945, pages 300-302.

biotics, there has been a tendency to view VD infections lightly. As Dr. Clarke of the American Social Hygiene Association has said, "you can't substitute medicine for morals."

In the use of the "contact investigation" technique, early syphilis patients are interviewed to obtain all necessary identifying data of their sexual partners so that they in turn may be brought to the clinic for treatment and in turn interviewed. With the use of penicillin the outpatient clinic has virtually replaced the inpatient center and increased the importance of the role of the private physician who may rely on the health department to provide him with skilled interviewers and investigators.

A new method of "speed-zone epidemiology"[13] has been instituted in several cities to locate contacts of male gonorrhea. The procedure utilizes telegrams and "around-the-clock" investigators to bring in as many contacts as possible within 72 hours. The technique is most applicable to higher incidence zones of large metropolitan areas and its success will be evaluated in terms of the reduction of reported morbidity in the males, within six to eighteen months. In a four-month period in one large area there was a 40 per cent response for treatment through the use of telegrams alone. By all methods combined, two-thirds of all contacts named were examined within the six-day limit.

It is obvious that the success of the various measures of control will depend upon the continued and combined efforts of the United States Public Health Service, state and local health departments, the Armed Forces and the voluntary agencies.

Conclusion

The efficacy of education as a means of reducing venereal disease cannot be determined. But can we not safely assume that education in this area will have a positive effect on our young people?

We do have available for study, local, state, and national statistics on venereal disease infections and the age levels concerned. If the highest incidence of venereal disease is found in the age group immediately following the termination of high school education, does this not present a challenge to educators? And realizing that some young people do not complete their four years of high school education, should not this training come before the twelfth year?

13. "Speed-Zone Epidemiology Applied to Gonorrhea," *Social Hygiene*, Social Hygiene Division, New York Tuberculosis and Health Association, September, 1953.

Sex education is aimed at favorably influencing young people to view sex as a constructive force in their daily lives. There is agreement that the discussion of venereal diseases should be included in a unit on communicable diseases rather than in the area of sex education.

Some of the problems which are encountered in relation to the area of venereal disease education have been discussed. It is the hope of the writer that an awareness of the increased responsibilities on the part of the educators has been aroused. Our contributions to VD control can be in the form of comprehensive and broad educational programs which are designed to build positive concepts and which will motivate young people to seek desirable behavior patterns.

* * * * *

AN OPEN LETTER TO A.S.H.A. MEMBERS

Fellow Member:

Have *you* encouraged someone to become a member of The American School Health Association recently?

As you know, the Association has no paid staff, and no professional personnel employed to solicit members. New members come largely through efforts of members who feel the Association is worthwhile and who want their friends to enjoy the benefits of such membership.

Your own membership in the Association indicates your feeling of esteem for the Association and for *The Journal of School Health* to which your membership entitles you. In order that the Association may grow and prosper will you, personally, be responsible for getting one new member within the next month?

Clip the application blank from the front of this issue and hand it to someone you would like to have join the Association, or (perhaps also) send someone a "gift" membership.

If you would like someone to have a sample copy of The Journal, just send the name and address to your vice president in charge of membership.

Spread the good word and watch The American School Health Association Grow!

Yours for a growing Association,

J. K. RASH
Vice President
In Charge of Membership

WHAT ARE THE NURSES DOING TO RAISE THE STANDARDS AND STATUS OF SCHOOL NURSES?

L. VELMA SEANOR, P.H.N.
Health Co-ordinator Montebello Unified School District
Montebello, California

This is the first of a series of reports by panel members. Others will appear in successive numbers of the *Journal of School Health*. The responsibilities of the school nurse need to be clearly defined so that she may be able to function to her professional capacity within the school framework.

The school districts in California have received from our State Department of Education a publication of "Suggested Responsibilities of the Administrator, the Teacher, the Medical Advisor, the Nurse for the Health of School Children." This publication was prepared by California Joint Committee on School Health, representing the State Department of Education and State Department of Public Health. On this committee were school health people working in school health programs under Boards of Education as well as representatives from Departments of Public Health participating in school health under a generalized program.

In addition to this joint committee, the State Department of Education has an advisory committee on school health, which acts in an advisory capacity to Dr. Roy Simpson, Superintendent of Public Instruction for the State of California, on school health policies. This committee has as members the following:

School administrators
Classroom teachers
School nurses—employed by Boards of Education
School physicians—employed by Boards of Education
Health coordinators
Representative of a teacher training institution

and representatives from the following organizations:

American School Health Association, California Division
California School Nurses' Organization
California Dental Association
California Medical Association
California Optometric Association
California Association for Health, Physical Education and Recreation

Consultants to the Committee:

Consultants from State Department of Education
Consultants from State Department of Public Health

In some areas of California where School Health Programs were already established under Boards of Education, the local

health department in the area was encouraging school districts to join with them in a generalized program, and they of the health department would then provide the personnel to carry on the health services in the schools. Of course the school district would pay for these services. Some school districts accepted this offer. Many of the school nurses in these districts were not satisfied with this plan.

In Southern California there was a group of school physicians and school nurses who were much concerned over this trend. The school nurses employed by Boards of Education felt it was time for them to organize and be heard, and we have done just that.

The school nurses organized the California School Nurses' Organization, whose membership consists of only school nurses employed by Boards of Education. This organization hopes to become a section of the California Teachers' Association in the near future. A membership of 500 with 75% of its members belonging to the California Teachers' Association is required to have a section.

It is important for school nurses to belong to the teacher association as well as to their own professional organizations.

One of the goals of the California School Nurses' Organization is "To raise the standards and status of school nurses." By having better prepared school nurses, we hope to have more effective school health programs.

The qualifications for the certification of the school nurse in California have been under study for several years.

In 1950 the California School Nurses' Organization made a survey in which school nurses throughout the state gave their recommendations regarding the educational preparation they felt was needed to prepare them for the type of work they are expected to do. This group felt that a Bachelor's Degree, which included a number of specific courses for school nurses, be required for all school nurses in addition to their State R.N. It was also requested that these university or college courses be given in California State Colleges so that educational facilities will be more accessible to nurses who may wish to continue working while completing the required educational qualifications.

A State Committee on the "Preparation and Certification of Nurses for Public School Service" has been appointed by Dr. Roy Simpson, Superintendent of Public Instruction, State of California. On this committee are representatives from the following organizations:

American School Health Association, California Division
California Association of Elementary School Principals
California Association of Secondary School Principals
California Association for Health, Physical Education and Recreation
California School Nurses' Organization
California Association of School Administrators
California Public Health Officers Association
California State Nurses' Association
Los Angeles County School Nurses' Association
State Board of the Parent-Teacher Association
State Colleges
State Department of Public Health
State Universities — Department of Nursing

Consultants to the Committee:

Consultants from State Department of Education
Consultants from State Department of Public Health

The first meeting of this State committee was held December 12, 1951. The results of the survey made in 1950 by the California School Nurses Organization were presented at this meeting.

Two additional surveys have been made in California to help the State Department of Education determine what the qualifications of the school nurse should be so that she will be prepared to take her place along with teachers in our educational system, the public school. These two surveys were made by students working for their PHD. A state-wide study was made of the present and desirable functions and competencies of California school nurses employed by either Boards of Education or Boards of Public Health. Twelve hundred thirty-six school nurses having direct responsibilities for school nursing duties in public schools in California completed the questionnaires. The second study was an intensive case study approach to the problem made by personal interview in the San Francisco Bay area only.

The school physicians of the American School Health Association, California Division, have given the nurses their wholehearted support in maintaining high standards for the educational qualifications for certification of school nurses.

What about the school nurses' status in California in relation to other professional, certificated personnel in regard to salary, tenure and retirement? Many districts have placed the school nurses on the teachers' salary schedule. School nurses have tenure the same as teachers and are members of the Teachers' Retirement System on the same basis as teachers.

THE DEVELOPMENT OF A HEALTH EDUCATION WORKSHOP

IRMA B. FRICKE, R.N., M.S.
Supervisor of School Nursing

In the Evanston Schools many teachers were doing outstanding work in the field of health teaching. Progress, however, in developing a curriculum designed to establish desirable health habits and attitudes, through carefully planned health education programs, has been slow. We did not have a definite plan for health teaching in the classroom. There was no way of insuring a progressive sequence in health education, no way of preventing duplication or repetition, and no means of knowing what were the health interests and needs of Evanston children, nor how these could best be met.

It was felt that a Health Education Workshop might be one means of arousing interest and serve as a step toward the development of a school health curriculum. In the fall of 1952, it was agreed that such a Workshop should be held sometime during the summer of 1953.

Early in January a notice was prepared for presentation at the February Principals' and Supervisors' meeting. At this meeting the purposes of the Workshop were explained, questions answered, and mimeographed forms related to the Workshop were distributed to the principals for use in their buildings. During the last part of February another notice was sent to the principals, requesting names of persons who wished to attend. This was necessary in order to make plans for the correct number of persons attending. A temporary schedule was then planned around a skeleton outline sent by the director.

During the months of March and April many health materials were ordered for the use of persons participating in the Workshop. This included materials on all phases of health. Much of this material was free or inexpensive. Many persons capable of serving as speakers or consultants were also contacted. As nearly as possible, local doctors and persons were called upon, since they were in a better position to know our community and our health needs and would be available after the Workshop had closed.

During the month of May a teacher and a Service Club from one of our schools spent several hours marking the materials for the use of the "Workshoppers."

The following committees were set up to assist with the vari-

ous duties: exhibit, film, refreshment, clean-up, and library. Other committees were set up during the Workshop when the need for such arose. The Library Supervisor and her staff compiled a bibliography listing all health materials in the school and also those available from the Public Library.

Early in May, a Workshop Committee composed of School Board Members, parents, teachers, principals, nurses, the curriculum coordinator, and the supervisor of school nurses met to review plans as they had been set up. These people were invited to offer criticisms and suggestions as they saw the need. A real interest was shown and much helpful advice was given. Plans were then completed and mimeographed programs made up.

The Health Educator from the Evanston Health Department furnished many free health materials and offered his services in any way in which they could best be utilized. He also assumed responsibility for the ordering and returning of the film. The Nutritionist from the Health Department offered to assist in a consultant capacity.

The Workshop opened Tuesday morning, June 16, at Orrington School. Two large classrooms, the kindergarten room, library, and nurses' room were made available for the use of the Workshoppers. Prior to the opening of the Workshop these rooms had been set up with tables and chairs; exhibits of health materials assembled by our nursing staff were displayed on bulletin boards, and health materials assembled in the knidergarten room. The library was used as the general meeting place when the group met as a whole.

The Workshop consisted of speakers who brought interesting and informative messages on all phases of child health. These people gave their services without charge to the school, though this in no way limited the amount of help they were willing to give or did give.

When participants met in smaller groups, according to grade area indicated, health needs and interests of children were studied, as well as methods of meeting these needs and interests.

Surveys conducted in other schools were analyzed, particularly "Health Interests of Denver Children;" through a study of these surveys and other health literature and through discussions based on classroom observations and health records, conclusions were reached as to what are some of our health problems. Several health units based on this information were developed by the

groups. The units developed have been mimeographed and are being distributed to participants.

Judging from comments of those participating, it was generally felt that the Workshop was most worthwhile and that all had learned a great deal.

At the close of the Workshop an evaluation sheet was distributed in order to get the feeling of the group on all aspects of the Workshop. Generally, all expressed a genuine satisfaction and hoped that another could be held at some time in the future. A few found the chairs uncomfortable, and many believed not enough time had been allowed for group work. Since all felt they needed the number of speakers scheduled, the only method of permitting more time for group work would be to extend the Workshop time.

Skits prepared by the three groups were presented on the last day of the Workshop. These demonstrated in a humorous, unusual, and interesting manner knowledges of health gained.

Altogether, we had 23 teachers, 8 nurses, and 25 visitors attending the Workshop. Visitors included persons from the surrounding area, representatives from the Medical Society, Dental Society, health department, and instructors from the University of Chicago. One of the high school nurses, and a community nurse from a nearby suburb joined us as regular participants.

Some important outcomes of the Workshop were:

1. A better and broader understanding and acquaintance with all phases of child health needs and interests and methods of utilizing these knowledges in the classroom.
2. Insight into ways of determining child needs and interests and how these can be translated into classroom learnings.
3. A better knowledge of how to develop health units around health needs and interests, using the classroom as a laboratory.

At the outset, the Workshop participants divided themselves according to primary, intermediate, and upper group levels. When there were no speakers, teachers and nurses assembled in smaller groups according to interest level, where they discussd health problems and developed several health units.

The first morning of the Workshop was devoted to orientation. In the afternoon, the Curriculum Coordinator very comprehensively outlined for the group the method of developing health units. The Director also distributed outlines to assist and guide

the people in their thinking. Other guides for unit development were passed out among the groups during the Workshop time. The zeal and enthusiasm with which all participated was an important factor in making the Workshop a success.

4. Benefits gained from thinking through a problem and working through together to an intelligent solution.
5. A better understanding of how teachers and nurses can work cooperatively in promoting better health education.

It is hoped that the Workshop will serve as an incentive in creating a desire for complete health curriculum built especially for our own children's needs.

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CONNECTICUT REPORTS ON ITS SCHOOL NURSE PROGRAM

CECILIA M. WANDT

Since the early 1900's many changes in school nursing have taken place in Connecticut. However, the physical demands are just as heavy as they have ever been.

Four years ago the school nurses in Connecticut, feeling the need of an organization to further their interests and promote good rapport with related groups, formed the School Nurses' Organization of Connecticut. During the first year this group affiliated with the Connecticut Education Association and on October 30, 1953, they voted to become a conference group of the Connecticut State Nurses' Association as well as to continue their affiliation with the first named group. Although this organization is too young to evaluate all its activities, one accomplishment in this past year was the drawing up of personnel policies for school nurses in Connecticut. These policies have been accepted by the Public Health Section of the Connecticut State Nurses' Association and will be submitted to the employing agency.

The Connecticut School Nurse is eligible for certification as Nurse-Teacher through the State Department of Education and is eligible for retirement benefits through the State Teachers' Retirement Plan. To meet certification requirements, if she has not earned a Bachelor's degree, she must within two years show evidence of sixteen semester hours of credit for professional courses in an accredited college. These courses must include work in public health, school nursing, and education.

The School Nurses' Association of Connecticut has representation in the State Department of Education.

RECURRENCE OF RHEUMATIC FEVER IN SAN FRANCISCO PUBLIC SCHOOL CHILDREN — SPECIAL CLASSES VERSUS REGULAR CLASSROOM INSTRUCTION

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The management of the post rheumatic fever child presents a real problem for both the physician and school authorities. Certain general measures must be taken to aid in a special effort to build up the child's natural resistance to infection, to prevent further damage to the heart that may already be impaired as a result of illness. There is ample evidence that such children should be encouraged to undertake physical activities within their capacities. These limits should be determined, however, for each case largely on the basis of response to functional exercise tests, and the extent of heart enlargement.

The tendency of this disease to recur is well known. The frequency with which such attacks recur is apparently associated intimately with the age at onset.[1] It has been observed that the highest incidence occurs when the onset is under five years of age and remains so until the advent of puberty.[2] Prognosis for the cases which have onsets in adolescence is much brighter because the possibility of subsequent attacks is lessened. Opinions differ as to reasons for the abrupt change in susceptibility to the disease with the beginning of puberty. Some investigators indicate in their findings that it is due to the development of resistance by the host.[3] Jones and others have reported that attacks are less likely to occur five or more years after the initial illness regardless of the age at onset because of the development of immune processes.[4, 5, 6] Other

1. Wilson, M. G.; Lingg, C.; and Croxford, G.: "Statistical Studies Bearing on the Problems in Classification of Heart Disease: Heart Disease in Children." *American Heart Journal*, Vol. 4: 164, 1928.

2. Cohn, A. E. and Lingg, C.: "The Natural History of Rheumatic Cardiac Disease: A Statistical Study. *Journal of the American Medical Association*, Vol. 121: No. 2, January 9, 1943.

3. Stroud, W. D.; Goldsmith, M.A.; Polk, D.S. and Thorpe, F.G.: "Ten Years Observation of Children with Rheumatic Heart Disease. *Journal of the American Medical Association*, Vol. 101: 502, September 12, 1933.

4. Jones, T.D. "The Natural History of Rheumatic Fever and Heart Disease with Especial Reference to Etiology and Prognosis." *Bulletin*, Chicago Heart Assn. Inc., Vol. 15, pp. 1-6, 1937.

5. Kaiser, A.D. "Factors that Influence Rheumatic Fever in Children," *Journal of the American Medical Association*, Vol. 103, October 22, 1934, p. 886 f.

6. Leonard, M. "Puberty and Prognosis in Rheumatic Fever," *American Heart Journal*, Vol. 14, 1937, p. 192 f.

workers present data in support of the premise that it is puberty and not necessarily the length of time that has elapsed since the first onset that decreases susceptibility.[7] Cohn points out that the reason for this confusion is the failure to appreciate the fact that the majority of cases have their first onset between 7 and 8 years of age and at the end of five years puberty has arrived.[8] This author has also noted that cases with early age onsets are more prone to have severe recurrences and a reduced life expctancy under such circumstances than those cases whose onsets occur later in life.

With each recurrence, the possibility of damage and scarring of the heart valves increases the likelihood of manifest heart disease with a subsequent decrease in life expectancy. It has also been observed that rheumatic heart disease causes disabling and curtailment in normal activity in a sizeable percentage of cases which also necessitates development of special vocational guidance and training programs for suitable occupations.[9]

Uninterrupted bed rest throughout the initial attack in a hygienic environment, supplemented by a well-balanced diet and adequate therapy, appears to be one of the most effective measures for minimizing the danger of relapses. In this connection, Ash found a marked decline in mortality for a series of cases studied for five years who had prolonged bed rest at the onset of infection when compared with a previous group observed over the same length of time who had followed a regime of early ambulation.[10] The prevention of recurrent episodes is therefore closely associated with the problems of case management, maintenance of optimum health, avoidance of acute upper respiratory disorders, particularly those of a streptococcal origin, and environment. Also the type of home and school situation to which the child returns is most important.

In view of the time the student spends in school, it seems a reasonable hypothesis that the lack of protection here may be a major factor which allows the child to respond abnormally to recurrences.

Much time and effort are being spent today on the clinical and convalescent care aspects of this malady, but little consideration has been given to the matter of what type of school environment is best

7. Cohn, A. E. and Lingg, C. *Ibid.*

8. Cohn, A. E. and Lingg, C. *Ibid.*

9. Rutstein, D. D. "Need for a Public Health Program in Rheumatic Fever and Rheumatic Heart Disease," *Journal of the American Public Health Association*, Vol. 36, 1946, pp. 461-467.

10. Ash, R. Rheumatic Infection in Childhood. 15-20 Year Follow-Up." *American Journal Diseases of Children*, Vol. 76, 1948, pp. 46-52.

suited to the education of these children. This problem has special significance because the disease is an important factor in retarding the scholastic progress due to prolonged periods of enforced absence from school. Levitt in a series of 310 cases (8-13 years of age) found that 53.3 percent of the children were behind in their grade status at school.[11] In San Francisco, this author found in a sample of 498 cases, 39.6 percent who were overage in grade. Much of this may be attributed to the incidence of recurrent attacks which resulted in extended periods of absenteeism and a curtailed academic schedule following their return to school. The value of special education versus regular classroom instruction for inactive cases of rheumatic fever was studied in San Francisco for a period of two years. Some of the findings have been previously reported.[12] Emphasis in the Health Class is placed upon case management and a more personalized type of education which is geared to meet the individual needs of the child. Other features include teacher preparation in some phase of education for the teaching of exceptional children; small classes; curtailed teaching programs and length of the school day; enforced rest periods and a supplementary nutrition program.

The following terms used to differentiate among the groups studied are described:

1. *Regular Class Child* is one with a history of Rheumatic Fever, who, following convalescence and return to school, enters the normal class routine except for a possible restriction on physical activity.

2. *Health Class Child* is one with a history of Rheumatic Fever, who, following convalescence and return to school, enters a special segregated class with a modified curriculum, abbreviated daily schedule, individualized instruction, curtailed physical activity, enforced rest periods, and supplementary feedings.

3. *Indirect Health Child* is one who has had both *Regular and Health Class experience*, but who returns to school following his initial illness via the Regular classroom routine and is subsequently transferred to a Health Class on the recommendation of his physician because of his inability to progress satisfactorily or because of a recurrence of his illness.

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11. Nebelung, Raymond G. "The Value of Segregated Classes Versus Regular Classroom Instruction for Post Rheumatic Fever Children." *Journal of School Health*, May 1953 and June 1953 issues.

12. Levitt, J. and Taran, L. M. "Some of the Problems in the Education of Rheumatic Fever Children." *Journal of Pediatrics*, Vol. 32, No. 5, May 1948, p. 555.

4. *Inactive Rheumatic Fever* "implies that activity for the time being has ceased, and yet there is enough evidence in the clinical structure picture or in the patient's history to indicate that he has had one or more attacks of this disease."[13]

Method of Investigation

Information on recurrent attacks was obtained from individual case history cards kept at the Board of Health. It was obtained by the Cardiac Register from private physicians and clinics through the routine follow-up practices of nurses; also by the Register's policy of sending out self-addressed report cards to private physicians and clinics at periodic intervals and through personal contacts.

Field visits were made to the Board of Health to transcribe the data from the Register. Work sheets bearing the name of each case were used to check against the individual history cards. Subsequently, the lists were checked a second time against the child's attendance record which had been obtained from the cumulative school record card. This record proved to be a valuable instrument for checking the degree of completeness of reporting relapses against the Cardiac Register. In the event there was an extended period of absence from school and no information was available relative to a recurrent attack, the case was referred back to the Registry for follow-up. Personal contacts were made with parents to determine the cause of absence, also with the physician or clinic for confirmation of diagnosis.

Sample Characteristics

At the beginning of the study the Register contained 632 cases, 134 of whom were eliminated for diverse reasons. Complete data were obtained on 498 children with varied racial backgrounds whose initial illness ranged from 1944-1949 (6 years). Lack of cases prior to 1944 did not allow for comparison between the two groups. No cases which occurred beyond 1949 were selected because a minimum of one year was allowed to elapse so as to be reasonably certain that the child had recovered from his initial illness before returning to school. Both groups were studied on the basis of the year of onset of infection. The sample was distributed throughout 92 schools in the city of which 72 were elementary, 10 junior high, 9 senior high and 1 continuation.

13. Paul, John R. *The Epidemiology of Rheumatic Fever.* Printed for the Metropolitan Life Insurance Company, 2nd ed. 1943, p. 15.

Sex distribution included 245 males and 253 females. Age at onset ranged from 4 through 17 years with an average of 8.5 years. The most frequent age of occurrence was 7 years for both sexes. Fifty-eight percent of all cases occurred in the age group 5-9. Three hundred forty-five cases attended regular classes and 153 had health class experience. Onset age for the former group ranged from 4 through 17 years with an average age of 8.6. That for the health class was from 4-13, with an average of 8.1 years. Fifty-five percent of the class in the regular class occurred in the age group 5-9, compared to 60 percent for the health class. Age 7 was the most frequent onset year for both groups, with 13 and 17 percent respectively. Forty-seven percent of the regular class were males compared to 55 percent for the health class.

Findings

One hundred eighteen, or 24 percent of the 498 cases, had at least one recurrence during the six-year period covered by this study. The range was from 7 to 39 cases, or 13 percent in 1949 to 43 percent in 1944. Incidence in the five and six-year samples (1945-1944) was 28 and 43 percent respectively, for all groups. In these two onset years, 36 percent of the cases had one or more recurrences. These data not only point out the serious nature of this disease as a major problem of public health importance, but also its chronic disposition and tendency to recur over a period of years.

The range in terms of percent of the total cases was from 6 percent in 1949 to 33 percent in 1944, while that for the total attacks was from 5 percent in 1949 to 37 percent in 1944. The two years with the most recurrences (1944-1945) were responsible for 55 percent of the total cases and 58 percent of all attacks. One hundred eighteen cases, or 28 percent of the total sample (498 cases) had 140 attacks.

The age at recrudescence ranged from 5 to 18 years, with the average onset age being 10.7 years for all groups. Onset age for the Regular Class ranged from 5 to 18 years with an average of 10.6 years; Health Class range was from 6 to 17 years, with an average age of 10.8 years; while that for the Indirect Health Class ranged from 8 to 16 years, with an average of 11.2 years.

In a series of 3,129 cases studied for an average of 13 years after initial onset of illness, Cohn found that 75 percent of them had one or more recurrences, 51 percent had two, 32 percent three,

20 percent four, and 12 percent five or more attacks.[14] Wilson, Cohn and other observers have also shown that the rate of recurrence is much lower when the onset of the disease is at the beginning of puberty (11-13 years of age), than when it occurs earlier in childhood.[15]

This observation undoubtedly accounts for the lower rate of attacks observed for this study group (28 percent) compared with the findings of other workers, because the average initial age at onset for this group was 8.5 years.

Forty-two, or 36 percent of the cases occurred one year after their first infection. These findings compare very favorably with those of Wilson and Lubschez, who noted in their series of 499 patients (comprised of a random sample) that "risk of recurrence during the year immediately following a major episode is 38.7 percent.[16]" However, the figures for the second and third year onsets in this study are larger than those reported by the above investigators. Eighty cases, or 68 percent of the total sample occurred in this two-year period. Inspection of the data for the first three onset groups (1944, 1945 and 1946) indicates that the most critical period appears to be during the first two years. Sixty percent of the cases in these three onset years occurred within the two year period following initial illness. On the basis of these data, it would appear that special precautions are necessary to protect the child against relapses, especially during this two-year period, by a high level of environmental care and prevention or early treatment of acute respiratory infections, particularly those of a streptococcal nature, if the danger of permanent scarring of the heart valves with subsequent damage is to be minimized.

Age specific recurrence rates were computed for each age group of the total sample for the purpose of making comparisons with findings of other investigators. Rates for each of the study groups (Regular, Health and Indirect Health Classes), however, were not prepared because of the paucity of cases in some of the age groups which might have unduly influenced any differences observed. In the evaluation of rates, it is recognized that there are numerous factors that must be considered such as age, susceptibility and environment of the groups being compared.

14. Cohn, A. E. and Lingg, C. *Ibid.*

15. Wilson, M. G., Lingg, C. and Croxford, G. *Ibid.*

16. Wilson, M. C. and Lubschez, R. "Recurrent Rates in Rheumatic Fever." *Journal of the American Medical Association*, Vol. 126, No. 8, October 21, 1944, p. 478.

Four hundred ninety-eight cases were under observation for a total of 1854 person-years between the ages of 4-17 years. For the age group 4-13 years, there were 138 recurrences for 1788 person-years of observation, or a rate of 7.7 percent. The rate for the 14-17 year group (15.4 percent) is unreliable because of the lack of cases. For the total group, age 4-17 years, there were 140 recurrences for 1854 person-years of observation.

The recurrent rate for the 4-13 age group, 7.7 percent, is practically the same as that noted by Jackson and his associates in Iowa, who observed 266 patients for a total of 893.5 person-years, between the ages of 4 and 21. These investigators found a recurrence rate of 7.9 percent for the age group 4-13 years who had received special attention to improve their diet and level of home care.[17] The findings of this study and those noted by Jackson differ, significantly, however, from those reported by Wilson for a random sample. Wilson found the average recurrence for the age group 4-13 years to be 25 percent. Adequate diet and good environmental care may be the reasons for the similarity shown between the Iowa treated cases and those in this study.

Table I shows the number of cases and attacks by onset years for each class.

TABLE I

Total Number of Cases and Attacks by Onset Years and Classes

	Regular			Health			Indirect Health		
Onset Year	Size of Sample	Cases	Attacks	Size of Sample	Cases	Attacks	Size of Sample	Cases	Attacks
1944	50	23	33	23	5	5	17	11	14
1945	60	17	20	21	3	3	12	6	7
1946	64	12	12	20	5	6	8	3	3
1947	62	6	6	18	1	1	9	4	6
1948	81	12	12	18	3	3	1	0	0
1949	48	6	6	5	0	0	1	1	1
TOTAL	345	76	91	108	17	18	48	25	31

Seventy-six children, or 22 percent of the Regular Class had a relapse compared to 17 children, or 16 percent for the Health Class; and 25 children, or 52 percent for the Indirect Health group. The high incidence of relapse among the Indirect Health Class is perhaps due in part to the fact that these children were more debilitated from their initial illness than were those in the other two groups. Consequently they were perhaps more susceptible to recurrences.

17. Jackson, R. L. et al. "Rheumatic Fever Recurrence in Children Without Sulphonamide Prophylaxis—An Evaluation of Environmental Factors." *Journal of Pediatrics*, Vol. 37, October 1947, pp. 390-402.

Table II presents the proportions and critical ratios of recurrent attacks for the Regular and Health Classes by year of onset.

TABLE II

Cases with Recurrent Attacks, Proportions and Critical Ratios, for Regular and Health Classes by Year of Onset

Onset Year	Total Sample		Total Cases with Attacks		Proportion Cases with Attacks		Critical Ratios (18)
	Regular	Health	Regular	Health	Regular	Health	
1944	50	23	23	5	.46	.22	1.967
1945	60	21	17	3	.28	.14	1,273
1946	64	20	12	5	.19	.25	.583
1947	62	18	6	1	.10	.06	.526
1948	61	18	12	3	.20	.17	.244
1949	48	5	6	0	.13	....	....

Analysis of the data in Table II showed only one significant Critical Ratio for the five sample years. The 1944 onset group had a P = .05.

The lack of significance in the next three sample years (1945, 1946 and 1947) may be due largely to the steady degree of improvement displayed by the Regular Class, even though the Health Class likewise continued to show improvement with the exception of the 1946 onset year when the proportion of cases surpassed that of the Regular group.

Although the proportions in four out of five years indicate a trend in favor of the Health Class, they lack significance except in one year. It would appear from these data that the possibility of recurrences for most cases is no greater in one class than it is in another.

Table III presents comparisons between the Regular and Indirect Health Classes for the same onset years.

TABLE III

Cases with Recurrent Attacks, Proportions and Critical Ratios for Regular and Indirect Health Cases—by Year of Onset

Onset Year	Total Sample		Total Cases with Attacks		Proportion Cases with Attacks		Critical Ratios
	Regular	I. Health	Regular	I. Health	Regular	I. Health	
1944	50	17	23	11	.46	.65	1.348
1945	60	12	17	6	.28	.50	1.486
1946	64	8	12	3	.19	.38	1.242
1947	62	9	6	4	.10	.44	2.742
1948	61	....	12	....	.20	....	....
1949	48	1	6	1	.13	....	....

18. See McNemar, Quinn, *Psychological Statistics* or any standard statistical test, for explanation of levels of significance for Critical Ratios.

Analysis of these data again showed a lack of significance except for one year. The 1947 onset group had a Critical Ratio with a P = .001 in favor of the Regular group. The trend in all four samples was in favor of the Regular Class, but it lacked significance in three of the four years. These findings are distorted because of the paucity of cases in the Indirect Health Class, particularly in the 1946 and 1947 samples; also because most of the recurrences in the Indirect Health Class occurred while the child was enrolled in the Regular Class group.

Nineteen out of the 25 recurrences took place in the Regular Class. Seven of these returned to school in the first year via the Regular Class; had a recurrence and were subsequently transferred to the Health Class. The remaining 12 were transferred from the Regular to the Health Class because of a below-par physical status. At periodic intervals, this group re-entered the Regular Class, had a recurrence of their illness, and following convalescence and return to school, again re-entered the Health Class. All of these cases returned to school via the Health Class before the end of the first term. The other 6 children who suffered recurrences while in Health Class were originally transferred to this Class because of a below-par physical status. The group as a whole constituted the more serious type of case as evidenced by the fact that 24 percent of the cases had a second relapse.

The Regular and Health Class were examined a second time to determine if there were any significant differences when the Indirect cases were redistributed on the basis of the locale in which their recurrent attacks recurred. The findings are presented in Table IV.

TABLE IV

Cases with Recurrent Attacks for Regular and Health Classes with Indirect Health Class Cases Added According to Locale in Which Attack Occurred

Onset Year	Total Sample		Total Cases with Attacks		Proportion Cases with Attacks		Critical Ratios
	Regular	Health	Regular	Health	Regular	Health	
1944	58	32	31	8	.53	.25	2.593
1945	66	27	23	3	.35	.11	2.353
1946	67	25	15	5	.22	.20	.206
1947	64	25	8	3	.13	.12	.130
1948	61	19	12	3	.20	.17	.388
1949	48	6	6	1	.13	.17	.274

Significant Critical Ratios were obtained in the 6 and 5 year samples (1944 and 1945) with a P = .01 and P = .05 respect-

ively. Except for the most recent year, in each of these samples the proportion of children who had fewer relapses was in favor of the Health Class.

Although the proportions in five out of the six samples were in favor of the Health Class which might be indicative of a trend, they lack significance in four of the onset years. It would appear that certain types of cases are less susceptible to recurrent attacks in the Health Class as evidenced by the high incidence of relapses that occurred among the Indirect Health group on re-entering the Regular Class.

Summary

A high level of environmental care is necessary to protect the child against potential relapses of this disease especially during the first two years following return to school, after the initial episode.

Although there is no clear cut evidence that the child will have fewer recurrences in one environment than in the other, some cases apparently are less susceptible in the Health Class than in the Regular Class until such time as they have reached an optimum degree of physical fitness.

Other aspects of this study previously reported, particularly in the areas of growth and scholastic achievement, indicate that Health Classes exercise a beneficial influence in the education of post rheumatic fever children, especially for the more severely debilitated type of case.[19]

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EDITORIAL COMMENT

COOPERATION IN A RURAL SCHOOL HEALTH PROGRAM

It is becoming increasingly evident that those responsible for the organization and administration of programs for healthful school living are recognizing the value of cooperative planning with groups interested in setting up and maintaining an effective school health program. In one of the more remote rural areas in the foothills of the Ozarks, a visiting team consisting of physician, nurse and health educator worked effectively with the county school superintendent, rural school teachers, and local medical representatives to make a health survey in several isolated small rural schools, with a total of three hundred eight pupils enrolled. The area was one in which money was scarce and needs plentiful. Roads were hilly and unpaved, and in many places hazardous.

19. Nebelung, Raymond, G. *Ibid.*

What was found was not unexpected, since a number of the children had never before had a complete health examination. A high incidence of physical defects was recorded, for many of which subsequent correction was made possible only through the combined efforts of local health and school authorities and various health agencies. Two severe cases were hospitalized, (one orthopedic and one vision) and while complete or partial correction could be reported in only twenty percent of a total of three hundred ninety five listed defects, this was still an advance over the records of previous years, and was made possible only because parents had been alerted and resources made available through the combined efforts of a persistent administrator, several patient rural school teachers, and the help of the various health agencies. —*M.A.H.*

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THE AMERICAN DENTAL ASSOCIATION SPONSORS TWO-DAY MEETING

Chicago.—Continuing cooperation between the dental profession, school teachers and administrators, parent organizations and other civic groups is needed to establish and maintain an effective dental health education program in schools.

This point was emphasized by both educators and health workers at a conference of representatives of 16 national education and health associations held in Chicago on Jan. 25 and 26, to review current dental health education programs now in effect for the nation's school children.

Conference participants agreed that dental health education, to be effective, should be an integral part of the regular curriculum.

The conferees also suggested the need for teaching a child to develop a critical attitude toward advertising, particularly that for such products as dentifrices, sweetened beverages and candy.

Other suggestions made by conference members included:

1. State and local dental societies should hold workshops on dental health education in cooperation with educators.
2. Toothbrushing programs should be encouraged in schools.
3. A program of pre-school dental examinations should be established similar to the pre-school medical examinations now required by many schools.

Mr. Perry Sandell, director of the A.D.A.'s Division of Dental Health Education, presided at the conference. The American School Health Association was represented by Dr. Mabel Rugen, Professor of Health Education, University of Michigan, School of Public Health.